Dual Eligible Stakeholder Meeting
Tuesday December 20, 2011 9:00 am– 12:00 pm
208 Hurricane Lane, Williston
Large Conference Room

Present: Present: Jeanne Hutchins, FAHC; Janet Dermody, VCIL; Judy Morton, VHCA; Rachael Parker, VHCA; Ron Cioffi, RAVNA; Sara King, RAVNA; Julie Tessler, VT Council of DMHS; Marlys Waller, VT Council of DMHS;; Brendan Hogan, Bailit Health; Theo Kennedy; Bailit Health; Devon Green, VT Legal Aid; Julie Trottier, Peter Cobb, VAHHA; Chrissie Racicot, HP; Cathedral Square; Laura Pelosi, VHCA; Betsy Davis, SASH; Walter Leutz, Brandeis University; Christine Bishop; Brandeis University; Kathleen Denette, Rate Setting; Jason Williams, FAHC; Larry Goetschius, Addison County Home Health; Debbie Austin, DVHA; Margaret Joyal; WCHMS; John Barber, CVAA; Lori Collins, DVHA; Beverly Boget, VNACares; Sam Liss, SILC; Dennis Houle, Lamoille; Lila Richardson; Jen Gaudette, Carrie Hathaway, DVHA; Dion LaShay, Consumer; Council; Susan Besio, PHPG, Debra-Lisi-Baker, Consultant;, Bard Hill, Julie Wasserman, and Tony Kramer Dual Eligible Project.

1) VIT session with Commonwealth Care Alliance
   Commonwealth's MCO "center of care" is based on primary care practices/medical homes. Better integration between VT's primary care practices and HCBS is important but VT's BP medical homes are not MCOs. The Duals Project will utilize Massachusetts statewide SCOs data.

2) Access to Medicare A, B and D data -- many challenges enumerated.

3) Guidance from CMS regarding financial model, including payments to states is pending.

4) Work with CMS and Mercer on feasibility of 'savings' is under way.

5) Demonstration model approval (forthcoming legislative discussions; CMS timeline.) Conversation w/ Legislature in January. Massachusetts has submitted their Dual Eligible planning proposal to CMS and is now taking public comment. Massachusetts' plan is to distribute the combined Medicare and Medicaid dollars to private MCOs who bear total risk for their population (including hospitalization, NF, etc).

6) Discussion of core design questions on handout.

Enrollment: passive enrollment with opt-out. Notices, appeals, options available will accompany enrollment/disenrollment process. Discussion on enrollment/disenrollment occurring monthly, quarterly, yearly with protections for consumers.

Every CIP would work closely with the BP CHTs. The ultimate point of responsibility would be with the CIP, although the BP CHT would be integrated into the person's care plan. We need to continue our focus on a person-directed system of care rather than focusing on how to meet the needs of providers.

RFP process to determine CIP participation. State will propose guidelines, measurable outcomes and standards. Should there be speciality CIP's? As long as the CIP takes full responsibility for their members and follows the guidelines and standards for a CIP, it may not matter. There seemed to be concensus around allowing multiple CIPs in a region and also the partnership alliance model. A variety of options are acceptable.

We need to revisit the Schematic and review the services to ensure each one is on the correct side (right vs left).